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ABSTRACT

Issues pertinent to prenatal drug-affected students are discussed in this ERIC Digest. The rising number of drug-exposed children approaching school age presents a challenge to school personnel in meeting their special needs. Topics covered are: (1) seriousness of the problem; (2) problems unique to drug-affected children; (3) creation of a classroom environment conducive to optimal development; and (4) the pros and cons of placement in special education programs. (7 references) (LMI)

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By Linda S. Lumsden

The problem of drug abuse "has developed a new face—the face of a baby," note Donna R. Weston and colleagues (1989). Although drug-affected babies have been present in our society for several years, their numbers have risen dramatically since the onset of the crack cocaine epidemic in the mid 1980s. Lorraine Carli, spokeswoman for the Massachusetts Department of Social Services, states that crack, a potent smokable form of cocaine, "seems to have become the drug of choice for women" (Mitchell Landsberg 1990). And New Jersey's acting health commissioner, Dr. Leah Ziskind, attributes the rising infant mortality rate in that state to "the drug-abusing pregnant woman, and especially her preference for crack" (Landsberg).

Today, the first crack-affected children are beginning to walk through the doors of public schools across the country. Many members of this new "bio-underclass," a term coined by drug abuse expert Douglas Besharov, will require special services for developmental, behavioral, psychosocial, and learning problems caused by drug exposure. As more and more drug-affected children approach school age, school personnel must be prepared to attend to the special needs of these children and their families/caregivers.

How Serious Is the Problem?

Hospitals are witnessing a disturbing increase in the number of infants born drug-exposed. When the Select Committee on Children, Youth, and Families conducted a survey of hospitals in 1989, fifteen of the eighteen hospitals surveyed reported a three- to four-fold increase in drug-exposed births since 1985 (George Miller 1989). And a recent national study of thirty-six hospitals conducted by the National Association for Perinatal Addiction Research and Education (NAPARE) indicates that approximately 11 percent of pregnant women use drugs during pregnancy. "Nationwide, an estimated 375,000 children each year are born exposed to cocaine," states Debra Viadero (1990).

Judy Howard, clinical professor of pediatrics at the University of California, Los Angeles, School of Medicine, makes the dire prediction that within a few years 40 to 60 percent of the students attending some inner-city schools will be children who were exposed to drugs while in the womb (Cathy Trost 1989).

What Kinds of Problems Are Prevalent Among Drug-Affected Children?

Researchers are beginning to identify a host of problems related to prenatal drug exposure. The characteristic behaviors of children who have been prenatally exposed to drugs are due not only to organic damage. Other risk factors—such as early insecure attachment patterns and ongoing environmental instability—also contribute to the difficulties.

Behavioral characteristics commonly seen in these children include heightened response to internal and external stimuli, irritability, agitation, tremors, hyperactivity, speech and language delays, poor task organization and processing difficulties, problems related to attachment and separation, poor social and play skills, and motor development delays (Los Angeles Unified School District 1989).

Initial findings of an ongoing study that is tracking 300 Chicago-area infants whose mothers used cocaine and possibly other drugs during pregnancy suggest that at three years of age many of the children have language problems and are easily distracted. Dan R. Griffith, a developmental psychologist participating in the study, which is funded by the National Institute on Drug Abuse, notes drug-exposed toddlers in the study also tend to score lower than non-exposed toddlers on tests measuring their ability to concentrate, interact with others in groups, and cope with an unstructured environment (Viadero).

Naomi Kaufman (1990) identifies other difficulties that may plague drug-affected children. "At the least," she states, "they include a much higher likelihood of lower intelligence; short attention spans; hyperactivity; inability to adjust to new surroundings and trouble following directions—all traits that can lead to failure in school."

It is important to keep in mind that not all drug-exposed children are affected similarly. Some children display relatively mild forms of impairment—perhaps displaying short attention spans and exercising poor judgment. The extent of impairment in others is severe; children with more serious problems may be unable to follow directions, engage in highly disruptive behavior, and have severe language difficulties.

Drug-affected babies and children are often described in terms of specific areas of impairment. Yet Weston and her colleagues warn that when we generalize about characteristics prevalent among drug-affected babies or the lifestyles and personal histories of drug-abusing women, we may unwittingly begin to engage in stereotyping. Every child must be seen as an individual who possesses a unique set of strengths and vulnerabilities.

How Can Schools Assist in Promoting Optimal Development?

Drug-exposed children, like children generally, progress more rapidly when they are in a predictable, secure, stable environment. School programs designed for these children, therefore, must include structure, clear expectations, and boundaries, as well as ongoing nurturing and support (Los Angeles Unified School District 1989).

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Teachers should strive to offset prenatal risk factors and children's stressful life situations by incorporating protective factors in the classroom and helping children cope with stress in more appropriate ways. According to the Los Angeles Unified School District, which began a pilot program for drug-affected three- to six-year-olds in 1987, attention should be given to the following areas when creating a classroom environment that will promote optimal development among drug-affected children:

- Have an adult-child ratio that is high enough to promote attachment, to provide adequate nurturing, and to assist children in developing more adaptive methods of coping.
- Create a predictable environment through regular routines and rituals.
- Show respect for children's work and play space.
- Organize the classroom so that materials and equipment can be removed to reduce stimuli or added to increase stimuli.
- Give special attention to transition time. Transition time should be viewed as an activity in and of itself. These transitional periods can help children learn how to deal with change.
- Attend closely to children's language development, social and emotional development, cognitive development, and motor development. Note how skills in these areas are being applied by the child during play periods, transition times, and while involved in self-help activities. Keen observation can provide insight into how a child experiences stress, relieves tension, copes with obstacles, and reacts to change. In addition, it helps teachers become aware of the ways in which children interact with peers and adults. (Los Angeles Unified School District)

Teachers should seek to acknowledge children's feelings before dealing with their misbehavior. This conveys the message that the feelings themselves are not wrong but the way in which they are acted upon may need to be altered. This approach often results in strengthening a child's desire to function within prescribed limits. Discussion of behavior and feelings helps children to develop the ability to distinguish between wishes/fantasies and reality, integrate their experiences, and gain self-control. Allowing children to make some choices in the classroom setting encourages a sense of responsibility and builds problem-solving skills.

In addition, those working with drug-affected children should view the home as an integral part of the curriculum, since research indicates that early intervention programs result in long-term positive change only when parent/caregiver involvement is emphasized. A genuine interest in the well-being of parents/caregivers can assist in establishing a strong home-school partnership.

Should Drug-Affected Children Be Placed in Special Programs or Regular Classrooms?

The price tag of addressing the needs of drug-affected children is difficult to estimate because it is unclear what proportion will need to be placed in self-contained special education classrooms, where the cost per pupil is considerably higher than in regular classrooms. Mary Ann Stowell, assistant director of special education in the Portland (Oregon) Public Schools, admits, "If I thought all of them were eligible for special education, I would be sweating bullets" (Kaufman).

The Los Angeles and Portland school districts both believe it is preferable to try to integrate rather than segregate drug-affected children unless it is apparent that they are urgently in need of special education placement. The stigma associated with enrollment in such a special program is one reason. Another is the high cost of educating children in special programs. The Los Angeles Unified School District spends up to $18,000 a year to educate each of the three- to six-year-olds in its Pre-Natally Exposed to Drugs (PED) Program. In comparison, about $4,000 per child per year is spent to educate children in regular classes (Trost).

Some districts are currently developing plans for educating teachers about the needs and problems of drug-affected children and how best to deal with them. The hope is that if regular classroom teachers receive intensive training, they will be aware of and able to attend to the needs of drug-affected children in the regular classroom. However, others fear that the quality of education in regular classrooms will suffer from the presence of drug-affected children and the demands they will make on teachers. This, they claim, may eventually result in a two-tier educational system, in which parents who can afford to do so may elect to enroll their children in private schools (Kaufman).

When working with drug-affected babies, "the challenge," state Weston and colleagues, "becomes one of learning how better to help drug-exposed infants with compromised capacities reach out to the world, and to support their families in creating a world worth reaching for." As these infants move through toddlerhood and into childhood, schools can join in this effort.

Resources

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